MDR: M4-03-5776-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective September 1, 1993 and Commission Rule 133.305 Titled (Request for Medical Dispute Resolution), a dispute resolution review was conducted by the Medical Review Division regarding a medical payment dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for inpatient hospitalization for dates of service 9-1-00 through 1-21-02.

   b. The request was received on 6-20-02.

II. EXHIBITS

1. Requestor

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. UB-92s
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

   The Requestor's documentation is reflected in Exhibit 1 of the Commission's case file.

2. Respondent

   a. TWCC 60
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

   The Respondent's documentation is reflected in Exhibit 2 of the Commission's case file.

3. Based on Commission Rule 133.307(g)(3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 5-20-03. The insurance carrier's response was received on 6-5-03; therefore, the insurance carrier's response was submitted untimely.
4. Notice of Medical Dispute is reflected in Exhibit 3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

   a. Position Statement dated June 20, 2002 from ___, ___, LLP

   "___ was seriously injured at work while employed by ___ (whose workers' compensation insurance carrier was ___). ___ was initially admitted to ___, but was transferred on or about August 14, 2000 to ___ to be near his family's residence. With the exception of a brief stint at ___ from December 11, 2000 to December 14, 2000 to received specialized medical treatment not available at __, ___ remained an inpatient at ___ from mid-August of 2000 until he died in January of 2002.

   Soon after the injury occurred ___ raised an entitlement dispute, claiming that ___ was not ___ employee and that his injury was therefore non-compensable. Likewise, the 'compensability' issue was the **sole** explanation ___ ever made to ___ to justify its denials of payment (as demonstrated by ___'s EOBs)…Finally, on January 4, 2002 ___ settled the compensability dispute by agreeing that ___ (___'s insured) was ___' employer and that his injuries *were compensable*. Then, on January 28, 2002 the Commission entered its decision and order based on the parties' agreement) that ___' injuries were compensable. At this point, ___ expected to be paid. Still, despite settling the compensability issue and making subsequent representations to ___ that it would be fully satisfied due to ___'s on-site audit findings that all services at issue were medically reasonable and necessary, ___ contended **for the first time** in March of 2002 that it did not have to pay ___ because ___ allegedly failed to obtain certain pre-authorizations."

2. Respondent:

   The insurance carrier did not submit a position statement.

IV. FINDINGS

1. Based on Commission Rule 133.305(d)(1-2), the only dates of service eligible for review are those commencing on 6-20-01 and extending through 1-21-02. Dates of service 9-1-00 to 6-19-01 were submitted untimely per above referenced rule.

2. Based upon the submitted EOBs the insurance carrier denied reimbursement for the inpatient hospitalization for dates of service 6-20-01 through 1-21-02 based upon "E – Entitlement (non-compensable), "The alleged worker was not an employee at the time of the alleged on the job injury. (Specify below as necessary) Per Adj." and "A-Pre-Authorization not obtained."

3. On January 4, 2002, the parties entered into a benefit dispute agreement the parties agreed the claimant was an employee of ___. Therefore, the claimant was an employee with worker's compensation coverage and the injury was compensable.

4. On January 28, 2002, K. Eugene Kraft, Hearing Officer of the Texas Workers' Compensation Commission, issued an Order to the insurance carrier to pay benefits in accordance with the Texas Workers' Compensation Act and the Commission's Rules.

5. Rule 134.600(h)(a)(1) states, "The insurance carrier is liable for the reasonable and necessary medical costs relating to the health care treatments and services listed in subsection (h) of this section, required to treat a compensable injury, when any of the following situations occur: (1) there is a documented life-threatening degree of medical emergency necessitating one of the treatments of services listed in subsection (h) of this section."

6. The requestor stated in their position statement that, "___ **factually rejects** ___'s allegations that ___ did not obtain necessary pre-authorizations. ___ documented ___'s pre-authorization approvals and can show that it gave ___ such authorizations for services rendered upon ___ through October of 2000. Then, in October of 2000, ___ informed ___ that it had closed ___ file due to its decision to dispute compensability and **demanded** that ___ refrain from making further pre-authorization requests. Accordingly, ___ is estopped from now asserting ___'s lack of pre-authorization as a defense to its obligation to fully satisfy ___ for the pertinent medical services rendered."

7. Impairment rating report from ___ dated 1-16-02, states in part, "His neurological damage ascended to the brainstem following his injury. The ascension of the damage is clearly demonstrated by his loss of ability to breath. He also loss initially and later regained a gag reflex. His lower level of normal function is at the level of the brainstem.

   He shows preservation of sensation of C2-C3 innervated areas however this sensation is abnormal. His examination demonstrates normal sensation of the face (fifth cranial nerve). He has no motor function below that provided by cranial nerves…This gentleman has at present a 99% Impairment of whole person. There is a possibility that this could be as much as 100% depending on his anorectal function and his neurological impairment of the bladder yet to be determined."

8. A review of the Discharge Summary dated 1-21-02 indicates that claimant had "sustained a injury ___ and since then has been a quadriplegic requiring permanent ventilation. Tracheostomy and a PEG has been done since. He has been having multiple problems with episodes of sepsis, pneumonia undergoing therapeutic bronchoscopies...C4-5 fracture dislocation….autonomic system dysfunction, pain, decubitus ulcer, contractures, psychosocial and psychological problems…urinary calculi, hypertrophic bladder, osteoporosis recurrent infections of the respiratory and urinary system and recurrent decubitus ulcers…status post sacral flap and colostomy. Fortunately the patient was able to

be discharged to TIRR on 01/21/02 in stable but critical condition." The medical records support the documented life-threatening degree of medical emergency necessitating inpatient hospitalization.

9. The Provider billed the insurance carrier $418,362.84 commencing on 6-20-01 and extending through 1-21-02.

10. The insurance carrier paid a total reimbursement of $0.00.

11. The total amount in dispute is $418,362.84.

12. Per Rule 134.401(c)(6)(A)(i), to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000. $418,362.84 exceeds $40,000; therefore, the stop-loss methodology applies to this admission.

13. The principal diagnosis noted on the UB-92 was 518.81. Per Rule 134.401(c)(6), diagnosis code 518.81 is not a diagnosis identified in section (c)(5). Therefore, the inpatient hospitalization is not exempt from the Stop-loss methodology.

14. Rule 134.401(c)(6)(B), "Formula. Audited Charges X SLRF – WCRA."

15. Per Rule 134.401(c)(6)(B), the Stop-Loss Formula results in an appropriate reimbursement of $418,362.84 x 75% = $313,772.13.

Therefore, the requestor is entitled to reimbursement of $313,772.13.

The above Findings and Decision are hereby issued this 6th day of October 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

V. ORDER

Pursuant to Sections 402.042,413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the respondent, ___/___ Insurance Company, to remit $313,772.13 plus all accrued interest due at the time of payment to the requestor, ___, within 20 days receipt of this order.

This Order is hereby issued this 6th day of October 2003.

Craig H. Smith, Deputy Executive Director
Texas Workers' Compensation Commission

CHS/ep

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code § 148.3). This Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date this Findings and Decision was placed in the carrier's representative box. (28 Tex. Admin. Code §102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P. O. Box 40669, Austin, Texas, 78704-0012. A copy of this Decision should be attached to the request. **The party appealing the Division's Decision shall deliver a copy of this written request for a hearing to all other parties involved in the dispute (Commission Rule 133.305(p)(2).**